Evaluation of the Desirability and Feasibility of a Statewide Uniform Payment System

Report to the Senate Finance Committee and the House Environmental Matters Committee

Maryland Health Care Access and Cost Commission

November 1997

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Executive Summary

Pursuant to Senate Bill 97 "Maryland Health Care Access and Cost Commission - Modifications and Clarifications," passed by the 1997 General Assembly, the Health Care Access and Cost Commission ("HCACC") was required to study and make recommendations on the desirability of a statewide payment system for health care practitioners and payers. The Commission conducted a series of six studies, included as the Appendices of this report, in order to reach its conclusions. The Commission related its findings to five goals of the uniform payment system ("UPS") which were identified through a review of the statute and its interpretation by the Commission-appointed Payment System Advisory Committee ("PSAC"). Goals identified are cost containment, uniformity, reasonableness, enhancing consumer and purchaser information and facilitating free market negotiation between providers and payers.

The recommendations of the Commission to the Senate Finance Committee and House Environmental Matters are as follows:

1. **Repeal those parts of the UPS enabling statute which mandate the development of a payment system based on a fee-for-service system. Retain other portions of the statute that pertain to the Commission's authority to require edits on rebundling of services and to monitor payment in all types of health care delivery systems.**

2. **Continue to monitor changes in methods of payment, payment incentives, and reasonableness of costs to compensation.**

3. **Assure, through legislative or other means, that consumers can obtain information in advance of receiving a service from providers and payers on charges and reimbursements. This information should be readily available for services provided in the payer's network (i.e., provider is on payer's panel) and for services provided out of the payer's network.**

4. **Implement the PSAC recommendation to require payers to use rebundling edits and make the standards for these edits available to the public on request.**

Evaluation of the Statewide Uniform Payment System: Summary and Recommendations

Senate Bill 97 "Maryland Health Care Access and Cost Commission – Modifications and Clarifications," passed in the 1997 legislative session, requires the Health Care Access and Cost Commission ("HCACC") to study and make recommendations on the desirability of a statewide payment system for health care practitioners and payers (see Appendix 1). The legislation requires HCACC to evaluate the goals of the payment system, the appropriateness of the payment system mandated in §19-1509 to achieving these goals, the feasibility and desirability of including reimbursement methodologies other than fee-for-service to the payment system and the continuing need for the statewide payment system in light of changes in the health care market. The HCACC is required to report back to the Senate Finance and House Environmental Matters Committees by November 1, 1997.

In order to respond to this legislative request, the HCACC conducted a series of studies of the Maryland health care marketplace from April to September 1997 (see Appendices 2 through 7). The Commission then reviewed the findings of these studies in relation to goals of the uniform payment system. From this analysis, the Commission was able to draw conclusions and make the recommendations on the future of the uniform payment system ("UPS") presented herein.

Goals of the UPS

The goals of the UPS may be identified by examining the relevant provision of the Commission's enabling statute (Health-General §19-1509) and its further interpretation by the Commission-appointed Payment System Advisory Committee ("PSAC").

Although the statute does not explicitly list the goals of the payment system, it clearly does so implicitly. A primary implicit goal is that of ***cost containment***. For example, it is through the payment system that Commission-established annual health cost adjustment goals are enforced. The Payment System is intended to ensure that providers comply with cost goals that are to be established by procedure code and by specialty. Although the statute specifies a preference for voluntary and cooperative efforts between the Commission and practitioners to attain these goals, the law also empowers the Commission to set rates to achieve them, as a last resort. To further achieve cost containment, the statute also instructs the Commission to use the payment system to avoid overpayment of claims by establishing standards to prohibit: 1) the practice of upcoding, i.e., the use of a procedure code with a higher value than appropriate for the services actually rendered; and 2) the unbundling of procedural codes, i.e., the inappropriate use of multiple procedure codes in order to maximize payment.

A second statutory goal is to create ***uniformity*** in the system of payment for all practitioners that is, the state payment system is intended to introduce standards of commonly applied measures into the payment system for health care services. For example, the statute requires that the UPS establish relative value units that must be used by all practitioners,

regardless of specialty, and by all private sector payers. The law also authorizes the Commission to consider establishing uniform mechanisms to account for differences in underlying geographic costs.

A third goal of the payment system is ***reasonableness***. The statute requires the Commission to "ensure that compensation for health care services is reasonably related to costs" (Health General Article §19-1509 (6)(c)(i)). In doing so, the Commission is to consider both the practitioner's resources and the value of the service performed.

The PSAC expanded on the themes in the statute as it created a framework for payment system development. Although the statute clearly allows for the HCACC to establish rates under certain circumstances, the PSAC report downplays the rate setting aspect of the law. Instead, as envisioned by the PSAC, the payment system is to foster a market driven approach to cost reduction by encouraging price comparisons. Thus, a fourth goal of the payment system is to provide ***consumer and purchaser information*** on providers. In fact, the report states, "The primary goal of the payment system is to improve price information available to consumers and others. The system will provide a framework for the analysis of price information, permitting prices to be compared on standardized units of value very similar to the unit price system used in the purchase of other consumables" ("Final Report of the Payment System Advisory Committee to the Health Care Access and Cost Commission"; December 1996, p. 7).

In addition to enhancing consumer information, the PSAC added a fifth goal for the payment system which is ***facilitating price negotiation*** between payers and practitioners. When services are provided under contract and where there is no balance billing, the UPS is intended to help payers understand the basis for providers' charges and for providers to understand the basis for payers' reimbursements. In theory, this common knowledge would enhance bargaining. When services are provided in network, the results of negotiations between providers and payers would remain between the parties involved, so long as payment was based on the uniform payment system. On the other hand, when services are provided out of network or where balance billing is allowed, the PSAC adopted a different philosophy. In those cases, it would require public disclosure of payers' and providers' conversion factors so that consumers could calculate their out-of-pocket liability for a particular procedure and comparison "shop" for services (see "Final Report of the Payment System Advisory Committee to the Health Care Access and Cost Commission").

As stated above, SB 97 requires the Commission to evaluate the appropriateness of the payment system to its goals. In order to evaluate the goal of cost containment, the HCACC studied trends in health care charges, expenditures, and reimbursements. The paper prepared by HCACC staff titled "Analysis of Charges to Marylanders For Professional Health Care Services" (April 1997) focused on trends in physician charges using Health Insurance Association of America (HIAA) insurance claims data. Although limited because of the focus on charges only, the HIAA data indicate that the Baltimore region ranks midway between other regions in charges for medical, surgical, and pathology services. Charges within Maryland varied widely, with charges being higher in the Baltimore-Washington region and lower on the Eastern Shore and

Western Maryland. The lowest charges were for medical services, and the highest were for professional component radiology services. From 1994 to 1996, the rate of increase of charges average about 3% a year for the Baltimore region. This is consistent with normal rates of increase. Following the presentation of this paper, the Commission asked staff to also look at trends in reimbursements. The addendum to paper number 1 using data from the HCACC's database also indicates reimbursements increased by about 1.5% a year from 1993 to 1995 (see Appendix 2).

Data on charges and reimbursements from these two sources indicate that costs are not rising as rapidly in the Baltimore region as may have been expected when the uniform payment system legislation was enacted in 1993. In fact, charges per relative value unit in the Baltimore region appear to be within the national norm and to rank midway between other metropolitan regions. These data support the argument against implementing the payment system at the current time because enhanced competition appears to be containing costs.

The Commission examined the goal of payment uniformity by looking at how widely a uniform payment system based on fee-for-service (FFS) payment would apply in today's health care marketplace and whether the system could be relevant to methodologies other than fee-for-service. The paper "Fee-For-Service in Maryland" (April 1997) indicates that while FFS may be losing ground to other forms of payment under managed care, FFS is still a major form of payment in Maryland (see Appendix 3). An estimated 53% of the total Maryland population, excluding those on Medicare and Medicaid, pay on a fee for service basis. This includes the privately insured and the uninsured. Even within managed care, FFS is the dominant form of payment for specialty care. The available data did not permit an analysis of the prevalence of discounted FFS, which appears to be growing in specialty managed care services.

The Commission paper, "Inclusion of Non Fee-For-Service Payment Methodologies In The State Payment System" (September 1997), fulfilled a requirement of SB 97 that the Commission study the applicability of the UPS to other payment methodologies (see Appendix 4). This paper concluded that the proposed payment system based on the RBRVS cannot be readily translated to other payment methodologies such as capitation and salary.

From these last two papers, Commission concluded that while the UPS would bring uniformity to fee-for-service transactions, ***it would not create a broad basis for systematically making comparisons*** between fee-for-service and capitation arrangements. Therefore, the extent to which the UPS could accomplish the goal of uniformity would be a function of the prevalence of fee-for-service payment and its relevance would depend on whether fee-for-service is growing or declining as a payment mechanism. Our evidence to date indicates that managed care is growing in the State, currently representing about 40% of all commercial coverage. In managed care arrangements, FFS is declining as a means of reimbursement for primary care, while fee-for-service or discounted fee-for-service is still the dominant method of payment for specialty care. The Commission concluded a broader based payment system than the one mandated by statute would be needed to cover most transactions.

It is more difficult to evaluate whether the UPS could achieve the third goal of reasonableness of payment in today's marketplace. Testimony presented to the PSAC concerning the need for a "floor" or "ceiling" for payment yielded conflicting interpretations of "reasonable" payment. Providers argued for a floor and ceiling to assure "reasonable" payment. Payers, on the other hand, concluded that a floor and ceiling constituted rate setting, which they abhor under any circumstance and which, furthermore, may not be established except under the conditions specified in the law. The payers also argued that a floor would have a negative impact on cost containment. The PSAC reached no conclusion on the need for a floor or ceiling and made no such recommendation in that area. Therefore, as structured by the PSAC, the payment system does not set an external standard of reasonableness since it does not set an acceptable range of payment.

The goals of enhancing consumer information and stimulating negotiation should be viewed as tangential to cost containment goals. If health care expenditures appear to be contained, it is possible to assume that the marketplace is already working absent a uniform payment system. It may well be that consumers, providers, purchasers, and payers already have the information they require for competition to work. If this is true, the question that should be addressed is whether implementation of the payment system would have a marginal value that would exceed its implementation costs to payers, providers, and the State. The Commission estimated the costs to payers, providers, and to the Commission itself of actually implementing the payment system. The results were presented in a series of three papers: "Uniform Payment System Implementation: Implications for Providers" (July 1997); "Implementation of the Payment System: Estimated Implementation Cost for Payers" (July 1997); and "Uniform Payment System Implementation: Assisting Payers and Providers" (September 1997) (see Appendices 5, 6, and 7). All three papers examined both costs to convert to the UPS and costs for ongoing administration. The results of HCACC research indicate:

1. Payers are concerned about the disruption of provider networks and contracts that will be changed by implementing the UPS;
2. Payers will have fewer problems implementing the UPS than providers;
3. There appears to be no direct relationship between the size of the payer and costs of implementation;
4. Solo practitioners and small groups of practitioners will have the greatest difficulty implementing the payment system due to lack of sophisticated technology and personnel unfamiliar with Medicare's RBRVS; and, finally,
5. Implementing the payment system will require considerable HCACC staff support to provide Medicare RVUs to practitioners (physician and nonphysician), as well as to assist in answering questions about converting patient billing/management systems to the UPS.

Payers surveyed by HCACC staff demonstrated considerable variation in their estimates of the cost of implementing and maintaining the UPS. Still, the estimates ranged from .002% to 2.13% of premiums. Excluding one outlier, additional annual maintenance costs resulting from the UPS ranged from $0 to .53, per enrollee.

There was a more direct relationship between the size of a provider's practice and ease of implementation because large practices are likely to have more sophisticated billing software or arrangements with accountants and consultants to calculate conversion modifiers. At least 26% of solo practitioners surveyed do not ever use a personal computer in their practice. The Maryland Medical and Chirurgical Faculty (MedChi) estimates that there are 3,700 solo practices in Maryland. Cost of implementation for providers will also vary by the number of procedures that will need to be repriced so that single specialty groups will incur fewer costs than primary care or multi-specialty groups.

Results of the survey of practitioners in various settings indicate that considerable HCACC staff time and resources would be required to implement the payment system, particularly if a decision is made to provide RVUs directly to payers and providers. This alone is estimated to cost $17,000. Such assistance would likely be provided through a contractual arrangement. Because some RVUs are modified from year to year, HCACC support would need to be ongoing.

Recommendations

In September 1997, HCACC staff made a series of recommendations on the UPS based upon study findings. These recommendations included delaying the implementation of the payment system indefinitely; continuing to monitor payment systems; and requiring each payer to have rebundling edit software and to make the standards for rebundling edits available on request. A public hearing was held on these recommendations on September 30, 1997. Nine persons testified at the public hearing including former members of the PSAC, representatives of providers (MedChi and provider specialty groups); and payers (Maryland Blue Cross/Blue Shield and Maryland Association of Health Maintenance Organizations) (see Appendix 8).

On the basis of staff recommendations and public comment, the Commission made the following recommendations at its October 9th meeting:

1. **Repeal those parts of the UPS enabling statute, which mandate the development of a payment system, based on a fee-for-service system. Retain other portions of the statute that pertain to the Commission's authority to require edits on rebundling of services and to monitor payment in all types of health care delivery systems.**

   Discussion: The Commission believes the specific UPS envisioned by the legislature in 1993 has less relevance in 1997 due to the growth of other payment mechanisms,

such as capitation, and to enhanced competition in the health care marketplace. Any payment system for consumers in the future will need to be designed to cover a broader range of payment mechanisms than fee-for-service alone.

2. **Continue to monitor changes in methods of payment, payment incentives, and reasonableness of costs to compensation.**

   Discussion: While a system like the UPS is not needed at this time, there is clearly a role for HCACC, as a public entity, to continue to monitor changes that are occurring in practitioner payment methodology, provider incentives, and reasonableness of payment (Health-General §19-1509 (e)). Studies of payment should include the whole range of payment mechanisms in use in the State including capitation and discounted fee-for-service transactions and other mechanisms identified pursuant to Senate Bill 162, "Health Care Consumer Information and Education Act" (1997). Additionally, specific questions with regard to the adequacy of reimbursement and the comparability of payment methodologies for specific services or specialties should be addressed if there are indications of dramatic increases or decreases in costs or expenditures in these areas.

3. **Assure, through legislative or other means, that consumers can obtain information in advance of receiving a service from providers and payers on charges and reimbursements. This information should be readily available for services provided in the payer's network (i.e., provider is on payer's panel) and services provided out of the payer's network.**

   Discussion: The Commission agrees with the legislative intent behind HB 1359 "Health Care and Insurance Reform" that there is great value in making available to consumers timely information to assess their liability for payment when services are provided both in and out of a payer's network. At the public hearing, Maryland Blue Cross Blue Shield (see Appendix 8) indicated this information was available through a toll-free number by service and by current procedural technology (CPT) code. MAHMO also reported "most all" of its members had means to make this information available either through member services or a special telephone number set up for these types of inquiries (see Appendix 9). However, this information is not currently mandated to be available, and it is not known whether it is equally available in all health care delivery systems. The Commission strongly believes that all consumers should have ready access to this price information upon request in order to make more knowledgeable choices.

4. **Implement the PSAC recommendation to require payers to use rebundling edits and make the standards for these edits available to the public on request.**

   Discussion: The statute (Health-General §19-1509 (a)(4)(b)(4)) requires the HCACC to "establish standards to prohibit the unbundling of codes and the use of

reimbursement maximization standards." The recommendation of the PSAC accomplishes this mandate and addresses the legislative mandate of cost containment. While the HCACC recognizes the rebundling edits, themselves, may be proprietary, the Commission believes providers and consumers are entitled to know the general standards, in descriptive terms, upon which edits are based (see Appendix 10).

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REPORT OF THE
PAYMENT SYSTEM ADVISORY COMMITTEE
TO THE HEALTH CARE ACCESS AND COST COMMISSION

Executive Summary

As part of a comprehensive health reform statute enacted in 1993, the Health Care Access and Cost Commission is required to develop a payment system for health care practitioners in the State. The payment system was mandated to enable the Commission to achieve its statutorily required health care cost goals for Maryland. The system provides a uniform method for measuring volumes and relative costs of services rendered.

The payment system's major purpose is not to set rates for practitioners or payers. Rather, it is designed to permit prices and reimbursements to be compared more easily. The system will serve as a basis for fee-for-service payments made to practitioners by payers and individuals not covered by insurance. Payers include insurers, non-capitated services of HMOs, and self-insured plans. Practitioners include all health care practitioners licensed under the Health-Occupations Article who bill for services independently.

The statute (Health-General, §19-1509) requires reimbursement under the payment system to be based on three numeric factors: a practitioner's resources relative to other practitioners; the value of the service relative to other services; and a conversion factor to translate the relative values into dollars per unit of service. The Commission sets the value for services and resources. Payers and practitioners negotiate the conversion factor in the marketplace. Only if and when required health care cost goals are not met and voluntary efforts to meet these goals fail, may the Commission set the conversion factor. The Commission is directed to consider the Medicare methodology of the Resource Based Relative Value Scale (RBRVS) when developing the payment system.

Given the complexity of payment system development, the HCACC appointed a Payment System Advisory Committee (PSAC) chaired by David Salkever, Ph.D., Johns Hopkins University, to make recommendations to the full Commission. The Advisory Committee is comprised of 23 members representing consumers, providers, payers, employers, and the academic community. The PSAC, through the Commission, contracted with the Center for Health Economics Research (CHER) to create a preliminary payment system design based on the statute. CHER issued a series of twelve reports which were extensively reviewed by the PSAC at monthly sessions. A Robert Wood Johnson Foundation grant funded many of the costs of payment system development.

PSAC's recommended design features, summarized below, are the culmination of more than two years of deliberation. These deliberations have taken into account presentations by CHER and staff as well as public testimony.

The system design recommended is a market driven approach to health care delivery allowing great flexibility for negotiation of price when services are provided under contract or in a network and the insured is not subject to additional billing other than co-pays. When services are not provided under contract or are provided out-of-network, the PSAC has recommended a system that is more standardized so that consumers can shop comparatively and better understand their potential liability for payment. Specific recommendations are outlined below.

Recommendations for the Design of the Payment System

1. ***Adoption of Medicare's work, practice expense, and malpractice expense relative value units (RVUs)***

   a. Adopt Medicare's RVUs and update per Medicare's revisions.
   b. Adopt Medicare resource-based practice cost RVUs, once they are adopted by the Health Care Financing Administration (HCFA).

2. ***Inclusion of Anesthesia Services***

   a. Require all providers and payers to use American Society of Anesthesiologists (ASA) Relative Value Guide's units;
   b. Require all providers and payers to adopt a uniform definition of time units of fifteen minutes per unit; payers may retain their current policies of using whole or fractional time units;
   c. Require all providers to calculate time according to the AMA's definition found in Physicians' Current Procedural Terminology (CPT);
   d. Allow payers flexibility in the definition of time with respect to labor epidurals;
   e. Recognize that some procedures performed by providers of anesthesia will not be subject to this methodology; and
   f. Allow anesthesiology providers and payers to use either CPT anesthesia codes or complete set of CPT surgical codes for billing and payment purposes.

3. ***Number of statewide conversion factors (CFs) for all health carriers***

   a. In cases where a contract between payers and practitioners prohibits balance billing, the Commission should require one conversion factor for all services covered by that contract. The PSAC believes that carriers and practitioners should have the flexibility to contract with each other at a mutually agreed upon conversion factor.

   b. In cases where a contract between payers and practitioners permits balance billing, or

where there is no contract with practitioners, the Commission should require a single statewide conversion factor per payer and per product.

4. ***Number of conversion factors per practitioner***

a. In cases where a contract between payers and practitioners prohibits balance billing, the Commission should require one conversion factor for all services covered by that contract. The PSAC believes that carriers and practitioners should have the flexibility to contract with each other at a mutually agreed upon conversion factor.
b. In cases where a contract between payers and practitioners permits balance billing, or where there is no contract with payers, the Commission should require a single statewide conversion factor per practitioner and per practice arrangement.

5. ***Public Information***

a. The Commission should provide Maryland residents with general information on conversion factors and on the relative value system, and on how to use this information in shopping for health insurance and services.
b. The Commission should require carriers to provide their standard payment conversion factors to their policy holders, in cases where the contract between the carrier and the insured allows for balance billing for out-of-network services.

6. ***CHER's recommendation to establish a conversion factor floor and ceiling***

The PSAC reached no consensus on this issue. This report, therefore, will provide the views expressed at the PSAC meetings and at the public hearing.

7. ***Payment equivalence for non-physician providers***

a. When balance billing is permitted, a payer's conversion factor for all services provided by oral and maxillofacial surgeons, podiatrists, clinical psychologists, as well as manipulative services of chiropractors must be equal to the payer's conversion factor applicable to physicians' services.
b. When balance billing is permitted and services are provided by non-physician providers other than those specified immediately above, a payer must use one statewide conversion factor for each non-physician provider licensure category and may vary the conversion factor across licensure categories.
c. The Commission should conduct a study of the conversion factors currently used to reimburse non-physician providers.

8. ***Regional Geographic Adjustment Factors***

The Commission should require payers to adjust payment by the Medicare geographic practice cost indices (GPCIs) and geographic areas, both when services are in-network with no balance billing, and when balance billing is permitted.

9. Site-of-Service Differentials

The PSAC reached no consensus on whether to adopt or defer consideration of Medicare's site-of-service differentials to adjust payments.

10. Payment Modifications

a. Require providers and payers to adopt the global surgical periods and bundled service concept which are embodied in RBRVS.
b. Require providers and payers to use CPT code modifiers, where appropriate, or other means to identify when a procedure needs to be qualified.
c. Allow providers and payers to set their own policies for all other issues.

11. Rebundling Edits

a. Require payers to use some type of rebundling edits to support in general HCFA's unbundling service policy.
b. Allow payers to use any rebundling editing program of their choice, provided the program is generally consistent with Medicare's rebundling edits.
c. Require payers to make their rebundling standards available to the public, upon request.

Glossary

Balance Billing - Billing for the difference between a provider's charges and an insurer's reimbursement after all co-pays and deductibles are accounted for.

Capitation - A payment mechanism under managed care where providers are paid a flat, per member, per month payment regardless of the number of services provided.

CHER - Center for Health Economics Research.

Commission - Health Care Access and Cost Commission (HCACC).

Conversion Factor - Dollar unit that is multiplied by relative value units for a service to arrive at the price for the service.

CPT Code - Current Procedural Terminology - code as adopted by the American Medical Association, for medical procedures in Medicare's RBRVS system.

FFS - Fee-For-Service, a method of billing and reimbursement where payments are made for each service provided.

Global Payment Policy - A payment policy whereby evaluation and management and other services are combined with the major procedure performed.

GPCI - Geographic Practice Cost Indices - a system used by Medicare to adjust payment to capture the true geographic cost differences between areas.

HCFA - Health Care Financing Administration - a federal agency with authority over Medicare payment policies.

Malpractice Expense RVUs - Standard units used by Medicare to reflect malpractice insurance premiums.

Practice Arrangement - A practitioner's business office arrangement and legal structure. For the purpose of the payment system, the PSAC recommends defining different practice arrangements for the same practitioner as discrete legal business entities.

Practice Expense RVUs - Practice Expense Relative Value Units - standard units used by Medicare to reflect practice expense. Practice expense is based on historic charges, but Medicare is converting to a system emphasizing resources used based on service-specific practice cost.

PSAC - Payment System Advisory Committee - appointed by HCACC to advise on the design of the payment system.

RBRVS - Resources Based Relative Value Scale - a system designed to determine Medicare payments based on standardized units that align services on a single scale related to their work value and practice expense values.

Relative Value Guide - The American Society of Anesthesiologists' guide to the relative value of anesthesiology services. Anesthesia values are determined by adding a Basic Value, which is related to the complexity of the service, plus Modifying Units (if any), plus Time Units.

SOSD - Site of Service Differential - payment system adjustment for services that are commonly performed in a physician's office or that are performed in a hospital outpatient setting.

Unbundling - The use of two or more codes by a health care provider to describe a procedure or other service provided to a patient when a single more comprehensive code exists that accurately describes the entire procedure or service.

Work RVUs - Work Relative Value Units - standard unit used by Medicare to account for a provider's time, effort, skill, complexity, and judgement needed for services that are uniformly related to each other.

I. *OVERVIEW/INTRODUCTION*

The Maryland General Assembly established the Health Care Access and Cost Commission (HCACC) in 1993 to develop and carry out new policies affecting health care payers, providers, and consumers.[1] Included among the charges to the Commission is the development of a standardized system to compare payments for all health care practitioners.[2]

The payment system was mandated in statute to enable the Commission to attain its health care cost goals by providing a method for measuring volumes and relative costs of health care services rendered by providers. The system will serve as a basis for the fee-for-service payments made to practitioners by payers and individuals. Payers include insurers, non-capitated services of HMOs, and self-insured plans. Practitioners include all health care practitioners licensed under the Health Occupations Article who bill for services independently.

The payment system's major purpose is not to set rates. The primary goal of the payment system is to improve price information available to consumers and others. The system will provide a framework for the analysis of price information, permitting prices to be compared on standardized units of value very similar to the unit price system used in the purchase of other consumables. For the first time, payers, providers, and consumers will be able to discuss charges and reimbursements in terms of a common "currency."

Under Health-General Article, §19-1509, reimbursement under the payment system will be comprised of three numeric factors: a practitioner's resources relative to other practitioners; the value of the service relative to other health care services; and a conversion factor (i.e., dollars per units) to arrive at a price (See Diagram 1). The Commission determines the resources needed to deliver health care services and their relative value. Payers and practitioners are to negotiate the conversion factor. Only if and when mandated state health care cost annual adjustment goals are not met and voluntary efforts to meet these goals fail, may the Commission set the conversion factor. The statute directs the Commission to consider the underlying methodology of Medicare's Resource Based Relative Value Scale (RBRVS) when developing the payment system.

The Commission must also "ensure that compensation for health care services is reasonably related to the cost of providing the health care service" (Health-General Article §19-

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[1] See Appendix A for statute.

[2] While statute currently requires that the system be developed by January 1, 1997, HCACC has determined this date is unrealistic due to the complexity of the project and will seek a legislative delay until January 1, 1999.

1509 (c) (2) (i)). In making this determination, the Commission must consider a number of factors, including the cost of professional liability insurance, the cost of complying with government regulation, and geographic variations in practice costs. It is important to note that while the Commission is required to look at a number of factors affecting compensation, it is not required to include them all in a system of payment. For example, while the Commission must consider uncompensated care and the costs associated with faculty practice plans, the PSAC concluded that these factors could not be included as part of the payment system design because of practical problems in incorporating them in a market driven system. The Commission is also mandated to prohibit the use of unbundling codes for medical procedures and the upcoding of programs to maximize reimbursement.

THE PROCESS

Given the complexity of the task of payment system development, the HCACC appointed a Payment System Advisory Committee (PSAC) charged with making recommendations concerning the structure and functioning of the payment system. (See Appendix B for PSAC Committee's Charge). The PSAC, chaired by David Salkever, Ph.D., Johns Hopkins University, is comprised of 23 members representing consumers, providers, payers, labor, employers and the academic community (See Appendix C for a list of members and their affiliations). Commissioners Harold Cohen and Dennis Murray represented the Commission on the PSAC. The PSAC deliberated for several months on how to approach the task of payment system development and ultimately crafted an RFP for payment system design. HCACC contracted with the Center for Health Economics Research (CHER), a nationally recognized expert in this area, to create a preliminary design based on the statutory mandate. CHER issued a series of 12 reports that included specific recommendations for action (See Appendix D). These were received by staff and presented to the Advisory Committee over the course of several months. The PSAC met 22 times between August, 1994 and November, 1996. Several public hearings were held to obtain input on controversial issues from interested parties (See Appendix E for a list of PSAC sessions and public hearings).

It should be noted that the costs related to payment system development, including salaries and expenses, as well as a substantial portion of the CHER contract, were paid for by grant funds from the Robert Wood Johnson Foundation. HCACC was awarded a substantial two year grant from the Foundation in 1995 to finance most of the payment system development costs. The Foundation has also supplied technical assistance.

BENEFITS

The payment system will provide benefits to consumers, providers, and payers. Providing meaningful information to consumers regarding the costs of health care services is clearly an objective consistent with the mission of the Commission. If sufficient numbers of consumers use the payment system as a tool to make more intelligent decisions about provider services, access to care will be enhanced.

Having a single set of relative values for services provided by practitioners will facilitate negotiation of fee-for-service (FFS) contracts. Many practitioners are having difficulty accurately evaluating their contracts with payers. The PSAC believes that practitioners will benefit from having a uniform set of relative value units (RVUs) for services.

Payers will benefit from the payment system by having providers and consumers educated along a single scale of values for services and on the concept of a unit price associated with these values. Payers will have to change their payment systems to conform to rules of the state's payment system. As CHER reported, however some payers have converted or are converting to a system using Medicare's RBRVS.

SUMMARY

The PSAC concluded that Medicare's RBRVS is applicable to most physicians practicing in Maryland, and that Medicare's RVUs for work and practice expense apply to the types of services typically provided in the privately insured market. The PSAC also agreed that the American Medical Association Current Procedural Terminology (CPT) code used by Medicare to differentiate among medical procedures should be the primary coding system for the new system of payment.

The system design recommended by the PSAC reflects a market driven approach to health care delivery that allows for great flexibility in price negotiation between providers and payers for services provided under contract in a health care network where the insured will not be exposed to additional bills other than co-pays (i.e., no balance billing). When services are provided out-of- network, or where no contract exists between the practitioner and payer, the PSAC has recommended that a uniform system be used to facilitate comparison shopping among consumers who either can be billed for services their insurance does not cover or who are uninsured. Providers and payers will still set the market price of their services.

The payment system will enable consumers to know what their insurers will pay for a service, what the providers will charge, and what obligations for payment, above the copayment, will be incurred. Self-paying patients will also be able to determine their financial liability.

The report that follows constitutes the PSAC's recommended design for the payment system. The PSAC has taken into consideration the recommendations of CHER, the HCACC staff, and the public. To facilitate the Commission's review of this document, the recommendations of CHER and staff are included in the text, where appropriate. To assist interested parties, a glossary of terms commonly used in relation to payment methodologies is included on page 5. Also, the minutes of each meeting appear in Appendix E. This is the PSAC's final report in fulfilling its charge (an interim report was issued October 27, 1995).

The Commission will hold a series of public hearings on the PSAC recommendations and then formulate regulations for implementation.

II. *BACKGROUND*

Until Medicare's recent development of a standardized payment system, payment for the services of physicians and other professional health care providers was almost entirely a function of charges. A patient, without insurance, was and is still liable for the actual charge made by the patient's provider. Although some insurers also paid a provider's actual charge, payments made by most government and private insurers were based on the charges for the service in the provider's community. These payment methods are commonly referred to as Usual and Customary (U&C); Usual, Customary and Reasonable (UCR) or, in Medicare's parlance, Customary, Prevailing and Reasonable (CPR). These methods, which are simply a variation of one method, have two things in common; an upper limit on the payment amount and no uniform method of calculation. For example, the upper limit was typically the charge, set at some percentile of all charges in the community, for the same service; Medicare used the 75th percentile. Some insurers paid the lesser of the upper limit or the actual charge. Other insurers maintained a historical record of charges, by service, for individual providers. This record, often called a provider's "profile," was used to determine the amount a provider usually charged for a procedure; hence the term "usual charge." Insurers who developed usual charges paid the lowest of the upper limit, the usual charge, or the actual charge.

The payment methods outlined above have been criticized as inflationary. Moreover, national insurers such as Medicare noted that charge levels across communities often made no sense. For example, the payments for a certain procedure might be approximately the same in one community and, for no discernable reason, significantly different in another. Little effort was made to develop alternative payment systems in either the public or private sector, however, until Medicare began its initiative in 1983.

Before 1983, Medicare's focus had been on containing inpatient hospital costs because they constituted, by far, the largest item in the Medicare budget. With the introduction of the inpatient hospital Prospective Payment System in 1983, Congress and Medicare turned their attention to the physician component of the Medicare program. After a false start or two, Congress, in COBRA-85, mandated the development of a relative value scale for personal professional services. This law also established a Congressional advisory body known as the Physician Payment Review Commission (PPRC). In 1988, the PPRC recommended the adoption of a standardized payment schedule based on a *resource-based relative value scale* (RBRVS).

The RBRVS was developed by a group of consulting scholars at the Harvard School of Public Health in Cambridge, Massachusetts. An exploratory study of the merit of this approach involving the ranking of 27 physicians' services had been performed as early as 1979. Although

results from this and a 1984 follow-up study were unreliable, they provided the basis for a national study begun in 1985. This study evolved into three phases. In Phase I, relative values were developed for 18 specialties. Phase II involved the development of relative values for an additional 15 specialties. Phase III, completed in August 1992, developed relative values for some services that had not been addressed previously and refined estimates from the earlier phases. Phase IV, completed in 1993, included studies of the non-physician specialties of optometry, podiatry, and clinical psychology. Oral and maxillofacial surgery was studied in Phase I.

The relative values developed by the Harvard study focused on the work performed by a physician when providing a service. Work was defined as:

- time required to perform the service;
- technical skill and physical effort;
- mental effort and judgement; and
- psychological stress associated with the physician's concern over iatrogenic risk to the patient.

The Harvard group conducted its study in consultation with members of technical consulting groups (TCGs). Each specialty included in the study had a TCG comprised of physicians nominated by national medical specialty societies. The work relative values were the result of surveys of practicing physicians. In Phases I and II, the researchers interviewed about 3,900 physicians in 33 specialties. Each specialty developed specialty-specific relative work values for about 25 procedures. Cross-Specialty Panels, comprised of about 10 physicians each, drawn from the TCG's, linked all of the relative work values into a single scale.

The relative work values address three patient-related components: preservice, intraservice and postservice. Pre and postservice work includes preparation time, writing and reviewing records, and discussions with other physicians. Intraservice work refers to services provided directly to the patient. The work values for surgical procedures also include services provided in the "global surgical period"; i.e., services provided to the patient in the recovery room, normal postoperative hospital care, and office visits both before surgery and after discharge.

The American Medical Association retained a consultant to review both the Harvard study's methodology and the results. The consultant concluded that the study's results were "generally accurate, reliable and consistent" (AMA 1993). Many national medical specialty societies also conducted independent assessments of the values with mixed conclusions as to their accuracy. As a result of these studies, the AMA and some national medical specialty societies - as well as individual physicians acting on their own - submitted about 7,500 comments on the RVUs assigned to approximately 1,000 codes. In response, Medicare modified its refinement process and reexamined the RVUs for 791 procedure codes. After this review, higher values were assigned to about 360 codes, and lower values were assigned to 35 codes.

In addition to work values, the Harvard study developed relative values for physicians' costs of doing business (practice costs) and costs of specialty training. The practice cost values were not adopted by Medicare because of widespread criticism of the methodology that set these values as a function of the work values. Responding to the criticism, Congress enacted the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) requiring the use of historically allowed charges for practice cost relative value development and prohibiting different payments by medical specialty. Practice expense relative values were divided into two categories: malpractice insurance costs and all other costs (office staff and rent, supplies and equipment, etc.).

The RBRVS assigns a value to most of the services described in the American Medical Association's (AMA) Current Procedural Terminology (CPT) code. This coding system is updated annually by the AMA under a contract with Medicare. In 1991, the AMA and the national medical specialty societies established the AMA/Specialty Society RVS Update Committee (RUC). The RUC advises Medicare with respect to relative values for new and revised procedure codes as well as refinements to existing values. Although Medicare is not required to accept the RUC's recommendations, a high percentage of those recommendations historically have been accepted.

The relative values or *relative value units* (RVUs) are converted to a fee schedule by multiplying by a unit price called the *conversion factor* (CF). There are several advantages to this system:

- the RVUs are widely accepted in the provider community because of providers initial and ongoing involvement in their development and refinement;
- RVUs remove incentives providers have to perform procedures that are overpriced relative to the "costs" of producing them;
- a fee schedule can be developed independently of historical charges, resulting in greater administrative simplicity and causing payments to become more rational within and across both specialties and communities;
- existing relative values are refined and values for new CPT codes are developed annually.

The limitations of the RBRVS system are:

- there are no relative values for certain services; notably, anesthesia and clinical laboratory services;
- the applicability of the RVUs to services performed by various non-physician providers is unclear; and
- work estimates were developed for "typical" patients and may not, therefore, accurately reflect the work expended when a service is provided to a non-typical patient.

Medicare implemented the RBRVS payment system on January 1, 1992, and its introduction created widespread interest among both public and private insurers. A consulting firm's 1993 survey of 333 payers indicated that one-third, had or were implementing, a RBRVS system, and another 40% were considering it (CHER, 1993). The number of payers who have adopted the system, however, has not reached the level predicted by the survey. Determination of the actual dispersion of the system depends on who is doing the counting. The Blue Cross Blue Shield Association, reporting on the results of a 1994 survey, found about half of Blue Cross Blue Shield plans nationwide using RBRVS for at least one of its products. The American Managed Care and Review Association reported 40% of HMO's of all types (IPA, etc.) were using the system but less than 20% of PPO's. Another 1994 survey found 36% of IPA/Network model HMO's and 28% of PPO's using RBRVS. As of January 1995, 19 of 51 Medicaid programs had adopted RBRVS. Some states that had earlier considered adopting RBRVS abandoned the idea when they began focusing on enrolling large numbers of Medicaid beneficiaries in capitated plans. The predominant use of the system in the commercial insurance market is for managed care products **that include a fee-for-service component** (PPRC, 1995). A survey fielded by the Commission's staff in December 1995 revealed that the vast majority of insurers who are primarily known for their life insurance products continue to use "UCR" for their fee-for-service medical payments (MHCACC, 1996).

While the RBRVS was developed primarily for the purpose of pricing Medicare claims, it may also be used by providers, payers, and the public to compare medical care prices in a simple, straightforward way. The conversion factor is a "unit price," a concept familiar to virtually everyone who shops at a supermarket. Providers may compare payers' relative reimbursement rates by reference to this price. Similarly, the uninsured and partially insured, while often unable to estimate the breadth of services they will require from a provider and thus unable to estimate their total liability, will be able to compare relative prices across providers.

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III. *RECOMMENDATIONS*

1. *Adoption of Medicare's work, practice expense and malpractice expense relative value units (RVUs)*

a. Adopt Medicare's RVUs, and update per Medicare's revisions.

b. Adopt Medicare resource-based practice cost RVUs, once they are adopted by the Health Care Financing Administration (HCFA).

Discussion

The Commission is required to develop two numeric factors representing: 1) the relative value of health care services as compared to other health care services; and 2) the resources of a health care practitioner needed to provide particular medical services. In Medicare's current RBRVS system, these factors correspond to the work RVUs and the practice expense RVUs, respectively. The third factor in Medicare's reimbursement system, the conversion factor (CF), or dollar factor, is set by Health Care Financing Administration (HCFA) for Medicare. It will be determined by market forces in the Maryland system, as required by statute.

In Medicare's RBRVS system, work and practice expense values are reported for specific procedures by the CPT coding system. This code is commonly used by providers and insurers for billing.

The principal source of Medicare's work RVUs is the Harvard study cited above. Value of a service is considered in terms of complexity, time, and skill. Practice expense RVUs include overall practice and malpractice expense. Medicare's practice expense RVUs are currently based on historical charges rather than service-specific cost estimates. HCFA is funding three studies to develop resource-based practice RVUs by January 1, 1998.

The PSAC concurred with the recommendation of CHER that the payment system should embody Medicare's work RVUs. As CHER stated, "the Medicare work RVUs meet the legislative requirements of the payment system by incorporating elements of time, effort, skill and judgement" (CHER's *Final Report*, page 7). The work RVUs are also the subject of continuing validity checks and refinement.

The PSAC discussed the application of Medicare's budget-neutrality adjustments to the RVUs. These adjustments were Medicare's across-the-board reductions in their work RVUs, which occurred in 1993, 1994 and 1995 in order to maintain Medicare's existing budget during transitions in the system. Beginning with the 1996 RVUs, Medicare no longer adjusts for budget neutrality in the value units, and, instead, adjusts the conversion factor. The PSAC concluded these adjustments should not be applied to the RVUs of the Maryland system.

Although CHER had reservations about Medicare's practice expense and malpractice expense RVUs because they are based on historical charges, it recommended adopting these

RVUs as an interim method, pending the completion of HCFA's resource-based practice cost study. CHER recommended evaluating Medicare's detailed resource-based practice expense RVUs when available (CHER's *Final Report*, page 17).

The PSAC recommends adopting Medicare resource-based practice cost RVUs, once they are adopted by HCFA. The HCFA process of developing resource-based RVUs is itself a resource intensive effort with a continual review process by HCFA and the medical community. The scientific validity of prospective resource-based RVUs will be the subject of public scrutiny. The PSAC believes that the State will not wish to expend the resources to undertake an exhaustive and largely duplicative review. Some members of the Advisory Committee voiced concern that the Commission reserve the opportunity to revisit the resource-based practice RVUs if they appear to have a dramatic effect on particular physicians or specialties.

2. ***Inclusion of Anesthesia Services***

   a. **Require all providers and payers to use American Society of Anesthesiologists (ASA) Relative Value Guide's units;**
   b. **Require all providers and payers to adopt a uniform definition of time units of fifteen minutes per unit; payers may retain their current policies of using whole or fractional time units;**
   c. **Require all providers to calculate time according to the AMA's definition found in *Physicians' Current Procedural Terminology;*[3]**
   d. **Allow payers flexibility in the definition of time with respect to labor epidurals;[4]**
   e. **Recognize that some procedures performed by providers of anesthesia will not be subject to this methodology; and**
   f. **Allow anesthesiology providers and payers to use either CPT anesthesia codes or complete set of CPT surgical codes for billing and payment purposes.**

Discussion

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[3]"Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision." CPT '96, p. 41.

[4]Because of the nature of labor epidurals, some carriers have set limits on the time units that will be paid or use a basis for time that is different from the basis applicable to mainstream anesthesia procedures.

At this time, the Medicare RBRVS does not have resource-based relative values for anesthesia services. HCFA has used the American Society for Anesthesiology (ASA) Relative Value Guide. The ASA Guide divides service complexity into "base units" and adds time units separately. CHER reported that there are only a few work RVUs for anesthesia services from the Harvard study on which the RBRVS is based and recommended excluding anesthesia services from the system. The adoption of the ASA Relative Value Guide will create different work units for anesthesia services as compared to other physicians' services, including surgical services.

The PSAC discussed the issue of incorporating anesthesia services into the payment system several times. The PSAC concluded that anesthesia providers should practice in a market similar to their colleagues in other specialties. The Committee recommended that the ASA Relative Value Guide is a logical point for calculating a payment structure. In calculating payment, providers must adopt Medicare's definition of time and the AMA's method for calculating time. Practitioners and payers are to use either CPT codes for anesthesia or surgery for billing and payment. The PSAC also discussed the current and pending changes in HCFA reimbursement policies for anesthesiologists and CRNAs and agreed that this issue should continue to be monitored at the federal level.

3. ***Number of statewide conversion factors (CFs) for all health carriers***

   a. **In cases where a contract between payers and practitioners prohibits balance billing, the Commission should require one conversion factor for all services covered by that contract. The PSAC believes that carriers and practitioners should have the flexibility to contract with each other at a mutually agreed upon conversion factor.**
   b. **In cases where a contract between payers and practitioners permits balance billing, or where there is no contract with practitioners, the Commission should require a single statewide conversion factor per payer and per product.**

Discussion

Determining the number of conversion factors (CFs), or dollars per unit, that can be charged is key to standardizing the payment system. The CF (dollar figure) is multiplied by the relative values for a service to determine the ultimate price. The CF can be thought of, figuratively, as the "price per pound" (RVU) of health care.

CHER recommended that the Commission allow one statewide CF for all health carriers, across the entire scale of RVUs, and that the CF vary by product line. The principal argument CHER made in favor of one CF per carrier and per product line is that it would create uniform scales of payment that reflect relative resource costs among all services. CFs that vary by specialty or type of service would distort the relationship between payments and resource costs. Additionally, CHER held that single statewide CFs per payer are needed to ensure meaningful geographic adjustments of RVUs (another recommendation discussed below).

The PSAC recommended policy on CFs distinguishes between when balance billing is permitted and when it is prohibited. Balance billing reflects the difference between a provider's charges and an insurer's reimbursement, after application of all copays and deductibles. The principal criterion is whether insured persons are exposed to additional out-of-pocket payments for services. This would occur when an insured patient goes "out of network" for services. In this instance, the PSAC felt the payment system could best be used to inform consumers of potential financial exposure, and to enhance their ability to shop for health care services[5] (See Diagram 2a.).

The PSAC favors more flexibility under the payment contract when services are provided in-network and balance billing prohibited, than CHER's recommendation would allow -- including giving carriers the ability to contract with individuals or groups at a unique unit price per contract. Flexibility enhances the negotiation process between carriers and providers and is a desired consequence. Also, allowing only one CF per contract still maintains the uniform scale of payment advocated by CHER within each contract. The PSAC notes that requiring carriers to quote one payment rate enables providers, for the first time, to gauge the relationship of one carrier's rates to another carrier's reimbursement rates.

When services are provided without a payment contract (out-of-network) or balance billing is allowed, the PSAC favors using one CF per contract and per product. Thus, payers would use a single dollar conversion factor per unit for all providers for the same service. As the next recommendation indicates, providers will do likewise.

In contrast to the PSAC's recommendation, staff felt CHER's argument for one CF per carrier per product, regardless of whether services are provided under contract, was rational and that it is in both consumers' and providers' best interests for that as few CFs as possible to be used. However, the staff did observe that forcing indemnity carriers to adopt one CF may actually increase health care costs for consumers if indemnity plans' uniform CF is lower than what is currently being reimbursed.

4. ***Number of conversion factors per practitioner***

   a. **In cases where a contract between payers and practitioners prohibits balance billing, the Commission should require one conversion factor for all services covered by that contract. The PSAC believes that carriers and practitioners should have the flexibility to contract with each other at a mutually agreed upon conversion factor.**
   b. **In cases where a contract between payers and practitioners permits balance billing, or where there is no contract with payers, the Commission**

[5] Shopping for health care services would not be feasible in emergency care situations and when a hospital has sole provider relationships, e.g., for anesthesiologists or pathologists.

should require a single statewide conversion factor per practitioner and per practice arrangement.

Discussion

CHER recommended that the Commission allow one statewide conversion factor (CF) for all providers, across the entire scale of RVUs, and that the CF vary by practice arrangement. As with its recommendation for carriers, CHER argued one CF would create scales of payment which reflect relative values and resources among all services.

The PSAC recommends that the policy on CFs for practitioners distinguish between when balance billing is permitted and when it is prohibited. As with the previous recommendation on payers, the PSAC favors more flexible arrangements for providers when services are rendered under contract (in network) and balance billing is prohibited. To allow one CF per contract with a payer still maintains the uniform scale of payment advocated by CHER within each contract. Requiring practitioners to quote one charge enables payers to more easily compare charges among providers for similar services.

When services are provided without a payment contract (out-of-network) and balance billing is allowed, the PSAC favors using one CF per contract, per practice arrangement. Thus, practitioners would use a single dollar factor per unit for all payers for the same service. As the previous recommendation on payers indicated, carriers would play by the same rules.

The PSAC wants the payment system to enable the public to become wise purchasers of health services by making available information on prices. This information is particularly important when patients go out-of-network and are billed for an amount not covered by the insurer or when they are uninsured. Knowing the CF or "advertised unit price" will help the consumer compare physician charges. This information combined with knowledge of the payer's CF for the same service will permit insured patients to more accurately assess their remaining financial liability.

It is possible that some practitioners have more than one practice arrangement, for example, a suburban group practice and an urban clinic setting. Since the practitioners costs may vary in each setting, the PSAC recommends allowing the flexibility to vary CFs by practice arrangement. Furthermore, the PSAC suggests that "practice arrangements" be defined as "legal billing entities," not merely different geographical locations.

5. ***Public Information***

   a. **The Commission should provide Maryland residents with general information on conversion factors and on the relative value system, and on how to use this information in shopping for health insurance and services.**
   b. **The Commission should require carriers to provide their standard payment conversion factors to their policy holders, in cases where the**

contract between the carrier and the insured allows for balance billing for out-of-network services.

Discussion

The PSAC views a central objective of the payment system as providing information to patients on the costs of health care before consumers make purchasing decisions. The PSAC recommends that the Commission publish a range of conversion factors for carriers. In instances where the insureds are subject to balance billing, (e.g., for out-of-network services) or when consumers are uninsured, having both the carrier and provider CFs will allow patients to calculate their relative liability.

CHER recommended that the Commission make public the range of CFs that are allowed in the payment system and provide guidance on how to use this information in shopping for health insurance. The testimony at the June 4, 1996 public hearing indicated agreement by various parties with CHER's recommendation. At the same time, however, witnesses for the payers urged the PSAC to assure the confidentiality of individual carriers' CFs.

Although sensitive to carriers' concerns, the PSAC decided that maintaining the confidentiality of a carrier's standard payment CFs when patients are subject to balance billing is not in the interest of consumers. When there is out-of-pocket liability, informed patients want to know both their carrier's and practitioner's CFs in order to determine the providers whose services will result in additional charges and the relative magnitude of those charges. Conversion factors established by contract which do not involve any additional patient liability, on the other hand, are more sensitive and should be kept confidential. As a result, the PSAC recommends that the Commission require carriers to provide their standard payment CFs to their insured in cases where the contract between the carrier and the insured allows for balance billing.

6. *CHER's recommendation to establish a conversion factor floor and ceiling*

The PSAC reached no consensus on this issue. This report, therefore, will provide the views expressed at the PSAC meetings and at the public hearing.

Discussion

CHER recommended that the Commission establish a conversion factor floor of $35 and a ceiling of $65. CHER pointed out that two fundamental policy objectives embedded in the payment system statute are: 1) to establish payments that reflect resource use; and 2) to ensure reasonable compensation to physicians (CHER's *Final Report*, page 43). According to CHER, "establishing a range of CF levels allows for competition, while providing assurances of reasonable compensation" (CHER's *Final Report*, page 44). CHER recommended as its floor Medicare's non-surgical CF of $35 and as its ceiling CF of $65, based on studies of CFs of Blue Cross/Blue Shield plans and private insurers. CHER reported that commercial insurers' most often reported upper limit CF was $65 (CHER's *Recommended Design Features of the Maryland Physician Payment System*, April 17, 1996, pp. 124-125). This is based on national, not

Maryland-specific, data. Also, most insurers in the CHER surveys were using multiple CFs rather than a single CF.

The recommendation of a CF floor and ceiling is CHER's initiative, based on its understanding of the statute. The statute does not explicitly permit a range of allowable CFs or a floor and ceiling.

Staff's response to the CHER recommendation was that, at least initially, the market should determine the floor and ceiling prices. However, staff also felt that CHER's specific recommendation of an allowable range of $35 to $65 is arbitrary and may not reflect the range of private payer CFs in Maryland.

The PSAC was split along lines of health care providers and non-providers on this issue. Providers voted in favor of a floor and ceiling. Generally, they agreed with CHER's recommendation that a floor was necessary to ensure reasonable compensation, and that a ceiling was a fair concept to implement as well. As an example of provider sentiment, one provider PSAC member stated that controlling health care cost, while necessary, should not occur on the backs of the providers.

Non-provider PSAC members, on the other hand, voted against CHER's recommendation. They held that the statute did not generally call for rate setting, including an allowable range, except when the Commission determined that health care costs had exceeded expenditure targets. One member voiced the opinion that cost control was the main purpose of the payment system, and a floor is counter to this purpose.

The PSAC did not vote on the specific CHER recommendations of a floor of $35 and a ceiling of $65. Given the lack of consensus on **the concept** of a floor and ceiling, there appeared little value in formally voting on a specific floor and ceiling.

The issue of establishing a floor and ceiling was the subject of a public hearing on June 4, 1996. As in the PSAC vote, non-physicians testified against a CF floor and ceiling, while physician groups favored the concept of a floor. The Maryland Association of HMOs (MAHMO) characterized the creation of a CF floor and ceiling as "anti-business and anti-consumer," saying that such artificial barriers interfere with a free market system and would prohibit consumers from receiving less expensive care in some instances (MAHMO testimony, June 4, 1996, page 4). Representatives from Blue Cross Blue Shield of Maryland (BCBSMD) and Blue Cross Blue Shield of the National Capital Area also opposed floor and ceiling CFs, as restricting the ability of carriers and practitioners to negotiate in a competitive environment. The legislative representative for Med Chi testified CHER's recommendation for a CF floor may not have a statutory basis, although Med Chi would favor a floor price (Oral testimony of Jay Schwartz, June 4, 1996). [6]

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[6] However, Mr. Schwartz said he believed that the statute's provisions of possible cost controls on physician fees left open the possibility of setting a ceiling, indicating a ceiling without a floor is unfair.

7. *Payment equivalence for non-physician providers*

a. When balance billing is permitted, a payer's conversion factor for all services provided by oral and maxillofacial surgeons, podiatrists, clinical psychologists, as well as manipulative services of chiropractors must be equal to the payer's conversion factor applicable to physicians' services.

b. When balance billing is permitted and services are provided by non-physician providers other than those specified immediately above, a payer must use one statewide conversion factor for each non-physician provider licensure category and may vary the conversion factor across licensure categories.

c. The Commission should conduct a study of the conversion factors currently used to reimburse non-physician providers.

Discussion

The questions raised before the PSAC were: (a) for what categories of non-physicians, if any, do the work RVUs accurately depict the work expended; and (b) do the work RVUs apply to all of the services provided by specific non-physician practitioners.

While the focus of the CPT codes, developed by the AMA, is on services provided or billed by medical doctors, many of the codes are also accurate descriptors of services provided by non-physician providers such as doctors of podiatry, optometry, clinical psychology, and chiropractic. As a result, the *work* RVUs developed in the Harvard study which were assigned to these codes are representative of the time, effort, complexity, stress, and judgement expended or experienced by physicians and some non-physicians.

The PSAC based its recommendation for podiatrists, oral and maxillofacial surgeons, clinical psychologists, and some chiropractic services on the Harvard RBRVS research and the AMA's RVU Update Committee (RUC) that looked at whether the work of non-physician providers was equivalent to physicians. Oral and maxillofacial surgeons were studied in phase I of the Harvard research, and podiatrists, optometrists, and clinical psychologists were studied in phase IV. The Harvard research explicitly points toward equivalent work for psychologists and podiatrists; the same cannot be said, at this time, for the work of optometrists. Estimates of time spent per service by optometrists were lower than those of ophthalmologists. Manipulative services performed by chiropractors were studied by the RUC and recommended for inclusion in the RBRVS at equivalence with physicians.

For all other non-physician providers, the PSAC concluded that when services are provided in-network, payers and non-physician providers may negotiate their conversion factors. However, when services are provided out-of-network, a payers must use one statewide conversion factor for each non-physician provide licensure category and may vary the factor

across licensure categories. This approach does no prohibit payment equivalence with physicians; however, equivalence is not required.

It should be noted the CHER had recommended a different approach to the issue of non-physician provider equivalence with physicians.

CHER addressed the questions in terms of three issues: (a) comparability of work between physicians and non-physicians; (b) the opportunity cost of specialty training; and (c) differences in malpractice and other overhead expenses between physicians and non-physicians.[7]

CHER recommended setting differentials for LLPs and NPPs as follows:

(a) Pay oral and maxillofacial surgeons, podiatrists, clinical psychologists, and chiropractors at parity with physicians.
(b) Allow non-parity payments for optometrists, nurse practitioners, clinical nurse specialists, CRNAs and anesthesia assistants, nurse midwives, physician assistants, physical and occupational therapists, and clinical social workers.
(c) Develop a range of allowable CF adjustors that reflect differences in work per unit of time and malpractice premiums for each category of LLPs and NPPs using the Physician Payment Review Commission's (PPRC) recommended Human Capital Approach and Maryland-specific malpractice premium data.
(d) Full fee schedule payment should be made when there is both a physician-patient and NPP-patient encounter during the same office visit, while reduced payment should be made when a physician is billing for a service provided by an NPP, and there is no physician-patient encounter during the office visit.

The PSAC concluded that, outside of the Harvard team's research on the work value of services by specific NPPs, there is little evidence on these subjects to guide decision-making. CHER's recommended approach, based on the PPRC's human capital approach, attempts to address the issue in terms of investment in and the opportunity cost of training. The human capital approach, however, does not meet the needs of the payment system for a number of reasons.

First, this method fails to consider traditional market forces such as the supply of practitioners and the demand for their services. Second, it assumes that the length of an education directly equates to other factors such as difficulty and intensity. Third, it implies that physician specialties should also be reimbursed differentially.

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[7]CHER uses the distinction of three categories of providers; physicians, limited license providers (LLPs), and non-physician providers (NPPs). For the purpose of this paper, we consider LLPs and NPPs as one group termed "non-physician providers" and "non-physicians" (NPPs).

Evidence of persuasive data concerning the differences in the overhead expenses of physicians and non-physicians is sparse. Malpractice expense for many non-physicians is less than that paid by physicians. However, this is probably related to their narrower scope of allowed practice.

As a result, the PSAC concluded that for most NPPs, there is insufficient information to develop RVUs that reflect differences between physicians and non-physicians or between licensure classes of non-physicians. Since neither the appropriateness nor the magnitude of specific payment differentials between NPPs and physicians is known for many professions at this time, the PSAC recommends studying the differentials in the market.

8. ***Regional Geographic Adjustment Factors***

The Commission should require payers to adjust payment by the Medicare geographic practice cost indices (GPCIs) and geographic areas, both when services are in network with no balance billing, and when balance billing is permitted.

Discussion

Medicare adjusts for geographic cost differences through Geographic Practice Cost Indices (GPCI). There are three GPCIs for each geographic area corresponding to work, practice expense, and malpractice expense, respectively. These are weighted and summed as the Geographic Adjustment Factor (GAF). The Commission had previously heard from CHER on this structure of the Medicare GPCIs (CHER first report, August 3, 1995 and presentation to the Commission, on payment system design features, November 2, 1995).

The PSAC recommends the use of geographic cost differentials to account for regional practice cost differences. The PSAC concurred with CHER's recommendation that Medicare GPCI's for Maryland offer the best method of making adjustments, because these address practice cost differences rather than payment rate differences.

The PSAC recommends applying the GPCIs to RVUs for all services regardless of whether they are provided under contract or not under contract, i.e., whether or not balance billing is allowed.

The PSAC also reasons that it may be easier for providers and payers if there is one set of RVUs within each region, with Medicare GPCIs included. If the GPCIs would apply only to balance billing services, and not apply to non-balance billing services, two sets of RVUs would have to be mastered by the parties.

CHER has demonstrated that the Medicare GPCIs associated with the three geographic areas are a reasonable way to adjust for geographic differences in practice costs.[8] However, it

[8] Currently there are four Medicare geographic areas. As of January 1, 1997, HCFA proposes to collapse

should be noted that some carriers divide Maryland into three geographic areas, while others divide the State into five or six (See Diagram 2b., 2c., and 2d.).

9. *Site-of-Service Differentials*

The PSAC reached no consensus on whether to adopt or defer consideration of Medicare's site-of-service differentials to adjust payments.

Discussion

Medicare adjusts payments in the RBRVS system on the basis of whether the service is provided in a physician's office or a hospital outpatient department. This adjustment is referred to as a Site of Service Differential (SOSD). Medicare reduces the practice expense RVU by 50% when a service, which is frequently done in a physician's office, is provided in a hospital outpatient department. The reason for this adjustment is that physicians use less of their own resources in an outpatient hospital facility. Also, Medicare must pay a facility fee in the latter setting. Clearly, one of the goals of this policy is to encourage services to be delivered in the less costly setting of the physician's office.

The PSAC did not reach a consensus on the adoption of Medicare's SOSD. Medicare's Site of Services Differentials are currently being studied for revision.

Maryland into three areas.

CHER had recommended adopting Medicare's site of service payment differential for procedures commonly performed in physicians' offices when they are performed elsewhere. Medicare includes 690 procedures that meet this criterion, based on frequencies of procedures for the Medicare population. The SOSD averages to roughly a 20 percent reduction in payment when the specified procedures are performed in a hospital outpatient setting.[9]

Staff recommended rejecting Medicare's SOSD, while recognizing that this differential should be adopted at some later date. The staff believed a SOSD is rational because it refines RVUs to account for differences in the use of resources and because it removes the economic incentive providers have to favor one place of service over another. With a properly designed SOSD in place, providers would select the location for the service based on the best setting for the patient, not based on the location that maximizes income.

PSAC members, who recommended not adopting the SOSD, pointed out procedures commonly performed in a physician's office for Medicare patients which may not reflect those commonly performed in a physician's office in the under age 65 private payer population. The procedures subject to Medicare's differential were identified using Medicare's elderly population. If the criterion used by Medicare to identify these procedures is applied to the private market, a different set of procedures may appear.

Those PSAC members who voted to establish a SOSD believed the PSAC should recommend approval of the concept of a SOSD, even if implementation is deferred. They agreed with CHER's reasoning that a SOSD is a rational way to avert paying twice for direct costs and to remove incentives for deciding on the place of service. In addition, staff raised technical issues about the Medicare methodology for adjusting for the differential (i.e., 50% reduction to practice costs RVUs).

The staff also noted that the adoption of the SOSD at the outset would be too disruptive to the industry. The staff's February 1996 survey of carriers revealed that only one-third of all carriers employed a SOSD as a way to modify payment.

10. *Payment Modifications*

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[9] This is based on a 50 percent reduction applied to the overall practice expense share of 41 percent for all procedures. The actual reduction would vary by the practice expense share of the procedures subject to the SOSD.

a. **Require providers and payers to adopt the global surgical periods and bundled service concept which are embodied in RBRVS.**[10]
b. **Require providers and payers to use CPT code modifiers, where appropriate, or other means to identify when a procedure needs to be qualified.**
c. **Allow providers and payers to set their own policies for all other issues.**

Discussion

The PSAC decided to include only those Medicare payment policies that are integral to the formation of a service code's RVUs. The PSAC took the general view that the policies that are most important are those dealing with global periods and bundled services. These aspects are essential to the integrity of the RBRVS. If services covered under global surgical periods and other bundled services are allowed to vary, the relative values are no longer accurate. If procedures, which include bundled payment of pre and post-surgical office visits, are not bound with the corresponding global surgical policy, a downward revision to the relative value of these services would be required, in order to avoid overpayment. Importantly, the failure to require these two policies would cause inappropriate health care expenditures for the insured population subject to coinsurance and/or deductible liabilities, insured patients subject to balance billing, and the uninsured.

The PSAC decided to require providers and payers to use AMA CPT code modifiers, where appropriate, or other means to identify when a procedure needs to be qualified. Inclusion of specific modifiers would make the system more uniform. However, the PSAC does no recommend any payment policies associated with those modifiers.

CHER had recommended the adoption of a large number of payment policies and their associated modifiers:

a. Medicare's global surgical periods,
b. Medicare's site-of-service differential (separately discussed)
b. Medicare's bundled service policies,
c. The following CPT code modifiers and associated policies:
    i. 26 - professional component,

[10]The "bundled service concept" in this context refers to including in the charge for a procedure all items incidental to the service (e.g., normal medical supplies, drawing specimens, etc.) and not the "unbundling" issue discussed later in this paper.

ii. TC- technical component,
iii. 80 - assistant surgeon,
iv. 81 - minimum assistant surgeon,
v. 82 - assistant surgeon (when qualified resident surgeon not available).
vi. 50 - bilateral surgery,
vii. 51 - multiple procedures,
viii. 54 - surgical care only,
ix. 55 - post operative care only,
x. 56 - pre operative care only,
xi. 62 - two surgeons,
xii. 66 - surgical team.

CHER considered it important to include these policies, because without uniform definition of services, it is likely that payment will not equal resource input. (CHER's *Final Report*, page 35). CHER viewed the payment policy issue along a "continuum of importance to equitable payment" under the state's payment system (attached chart 2e. is a reproduction of a CHER exhibit depicting this continuum). CHER thus distinguished policies necessary to maintain the integrity of the RBRVS, e.g., global surgical periods on the one end, with policies for "unusual services" on the other.

CPT code modifiers 26 PC (Professional Component) and TC (Technical Component) represent special cases. The professional and technical components are subcomponents of selected services: primarily radiology; but also pathology, cardiology, and a few other services. The total component of a service comprises physicians' work and all expenses incurred in providing the service. The professional component comprises physicians' work and personal expenses but not other costs of providing the service; these costs are reflected in the technical component.

To illustrate this situation, first consider a radiologist who owns and operates an independent imaging center. The salaries of technologists, rent, equipment and all other costs are borne by the radiologist who also interprets the images. The radiologist's bill would reflect these costs. If the radiologist is working in a hospital, the radiologist interprets the image, but the hospital incurs the costs associated with creating the image; i.e., technologists' salaries, equipment, etc. The radiologist's bill should reflect only his/her personal or "professional" services, while the hospital's bill should be based on imaging or "technical" costs only.

The reason these situations are special in the context of the payment system is that professional and technical components are included in the RBRVS; i.e., RVUs have been assigned to these services. Therefore, if the PSAC's recommendation to base the payment system on Medicare's RBRVS is adopted, professional and technical component services automatically become part of the payment system. These services may be differentiated using modifiers or other means agreed to by providers and payers.

The PSAC notes the difficulty of incorporating various payment policies into a system that will be consumer friendly. The foundation of the payment system is the assumption that the patient will be sufficiently informed to shop for physician's services using physician's RVU prices. The PSAC does not believe it is reasonable to expect that the average person will ask about physicians' charge policies with respect to, for example, bilateral or multiple procedures or procedures that involve surgical assistants. Some important billing information regarding modifiers may be lost to consumers for the sake of clarity in understanding the payment system.

11. *Rebundling Edits*

a. Require payers to use some type of rebundling edits to support in general HCFA's unbundling service policy.
b. Allow payers to use any rebundling editing program of their choice, provided the programs are generally consistent with Medicare.
c. Require payers to make their rebundling standards available to the public, upon request.

Discussion

CHER recommended that the Commission adopt HCFA's rebundling edits, while also considering waivers or special exceptions for insurers who can prove undue financial harm. CHER's primary reason for adoption of Medicare's rebundling edits was to minimize overpayment due to unbundling. While CHER stated that carriers could create their own rebundling edits, it held that a secondary reason for adopting HCFA's edits would be to promote a uniform policy for both definition and billing of services for the payment system.

The PSAC agrees with CHER that rebundling edits are necessary to: (a) meet the statute's prohibition on unbundling;[11] and (b) be able to implement and monitor the policy that bundled services are reflected in the RVUs of many service codes. However, the PSAC agreed with staff's recommendation to allow flexibility to carriers in deciding which rebundling editing program to use.

The staff spoke with HCFA, the Government Accounting Office (GAO), the Medicare Carrier for Central Maryland and State's two teaching hospital-affiliated billing offices, and concluded that it is too early for the adoption of Medicare rebundling edits by the non-Medicare sector. Apparently, the current Medicare edits, implemented in January 1996, contain programming "bugs" and are undergoing periodic revisions. Furthermore, a case cannot be made that these edits are superior to rebundling edits available from private vendors. The primary advantage to the Medicare edits is that they are "in the public domain," whereas private sector

[11] Section 19-1509(b)(4)

edits have been characterized as "expensive" to purchase. The criterion of uniformity in unbundling policy, noted by CHER, could be achieved by requiring any broad rebundling program, not just Medicare's.

Moreover, the staff communicated with six carriers and learned that all of them use various commercial rebundling edits to their advantage. One carrier estimated the savings at 1 percent of claims dollars. GAO conducted a study using commercial edits and Medicare claims from the early 1990's and concluded that Medicare could save between 2 and 5 percent if the commercial edits were used. It is too early to tell what the latest version of Medicare edits will save in comparison to commercial editing programs.

The PSAC believes that rebundling edits are beneficial to carriers and, more importantly, to insured patients who have out-of-pocket payments. Unfortunately, the uninsured are unable to reduce cost via rebundling edits, since it is an insurance mechanism used only by carriers.

The PSAC also recommends that providers have the benefit of knowing about the rebundling standards of payers, upon request. Rebundling information is important to providers in order to understand the payer's reimbursement for services rendered.

Appendix C

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